
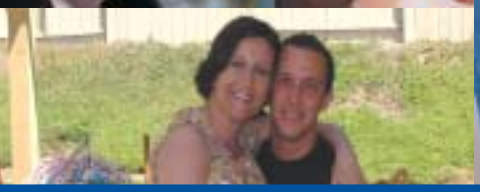


Washington State Diabetes Plan

Washington State Department of Health

March 2005

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Call To Action:

Join us in implementing The Washington State Diabetes Plan—goals and activities to prevent and control diabetes among the people of Washington.

Introduction

Diabetes contributes significantly to the nation's current epidemic of chronic diseases. Its costs—in morbidity, mortality, and health care spending—are immense and growing.

More than 6 percent of the U.S. adult population has been diagnosed with diabetes, and another 3 percent has the disease and doesn't know it. In Washington State, both the prevalence and impact of diabetes mirror national trends:

- Diabetes now affects nearly 1.3 million Washington residents—at least 270,000 who have been diagnosed with the disease, more than 100,000 who have undiagnosed diabetes, and at least 900,000 who have pre-diabetes.

- In Washington, diabetes prevalence has doubled since 1990, with the rising rate driven by an aging population, rising obesity rates, decreasing physical activity, and new diabetes diagnostic criteria.

- Diabetes is more common in persons 65 and older, in certain ethnic and racial groups, and among people at the lowest levels of income and educational attainment.

- In Washington, diabetes is the cause or a contributing factor in nearly 4,000 deaths a year. It is also a factor in more than 67,000 hospitalizations every year, and diabetes-related conditions account for more than $1 billion annually in hospitalization charges in our state.

- The current health care system, including the payment for care, is not designed to treat chronic disease effectivley, including diabetes.

A range of social, health, policy, and demographic factors contribute to diabetes and its dramatic increase in prevalence. To address a problem of this scope—to identify strategies and mobilize the resources needed to curb this increase and improve the lives of people who have diabetes—requires coordinated contributions by health and community leaders across our state. This broad array of health and community leaders is defined in the state plan as the new **Washington State Diabetes Network**.

About This Plan

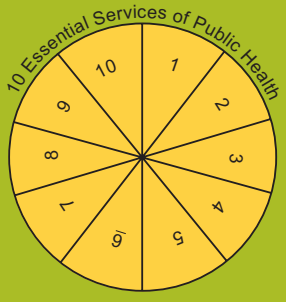
The State Diabetes Plan uses a widely applied framework: the 10 Essential Services of Public Health (ESPH). The ESPH, which were developed by national health policy leaders in the early 1990s, are the services necessary to keep every community healthy. Within this framework, the plan outlines goals and activities that are specific to the prevention and control of diabetes.

Throughout Washington, organizations and people work in one or more of the 10 ESPH to control and prevent diabetes. These organizations and people make up the new Washington State Diabetes Network. The next section presents a summary of the plan's goals and activities for each of the 10 ESPH (with the exception of Essential Service 6).

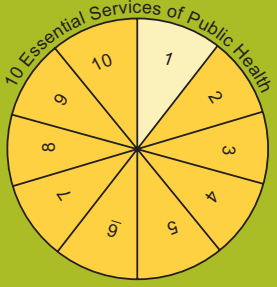
The "Alignment Wheel" that follows the summary shows the relationship of the essential services, the goals and activities to achieve them, and the organizations and people related to each of the goals.

A more comprehensive version of the plan can be found at http://www.doh.wa.gov/cfh/diabetes. For a more detailed description of the development of the plan, see the Appendix on page 13.

10 Essential Services of Public Health



1: Monitor health status to identify health problems.
2: Diagnose and investigate health problems and health hazards through ongoing screening activities.
3: Inform and empower people about health issues.
4: Mobilize partnerships to identify and solve health problems.
5: Develop policies and plans that support individual and statewide health efforts.
6: Enforce laws and regulations that protect health and ensure safety.
7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8: Assure a competent public and personal health care workforce.
9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10: Conduct research for new insights and innovative solutions to health problems.



Monitor health status to identify health problems.

Goal: An integrated surveillance system is supported that is compliant with the 1996 federal Health Insurance Portability and Accountability Act (HIPAA) and that provides consistent information for everyone.

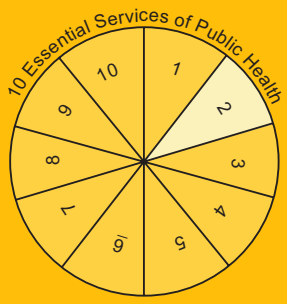
Activities:

- Establish a statewide work group to oversee implementation of an integrated surveillance system that incorporates all relevant computer networks and the information they carry.
- Encourage sharing agreements to improve access and use of electronic information, and work with partners such as the Indian Health Service, community health centers, and health care systems.
- Examine clinical data repositories and other clinical information for all network partners to analyze health disparities, identify information gaps, tie information to screening initiatives, and promote use of information by regional coalitions.
- Encourage all primary care practices in Washington to establish electronic registries or electronic health records.
- Create a database that captures information about people at high risk for diabetes, pre-diabetes, and undiagnosed diabetes and that tracks changes in the diagnosed population.
- Assess the feasibility of modifying surveillance approaches and the environment for electronic submission of information from providers in Washington.
- Assure resources for surveillance system development and appropriate staff and resources for ongoing management.

Goal: Comprehensive, evidence-based, and ongoing screening activities are conducted in all high-risk populations, using multiple sites and methods, that identify new cases of pre-diabetes and diabetes for the purpose of diagnosis and intervention.

Activities:

- Identify barriers to screening for hard-to-reach populations, and disseminate science-based screening standards to health plans, providers, and policy-makers.
- Promote a risk factor screening test through multiple means and culturally appropriate methods.
- Identify and implement an action plan to increase providers' knowledge of high-risk populations, and increase the glucose screening for all at-risk patients.
- Motivate all Washington residents to ask providers for regular screening, and assure that all people newly screened and found to be at high risk for diabetes receive information empowering them to seek appropriate diagnosis and treatment.
- Partner with employers to increase screening of employees while assuring compliance with HIPAA.
- Develop and communicate referral and follow-up procedures and resources for those with pre-diabetes or newly diagnosed diabetes for education, prevention, and treatment services.



Diagnose and investigate health problems and health hazards through ongoing screening activities.

Inform and empower people about health issues.

Goal: A comprehensive, coordinated, and measurable strategy is conducted to increase awareness of risk factors for diabetes and to empower individuals to take action to prevent diabetes, get screened, diagnosed, and receive treatment to manage their diabetes.

Activities:

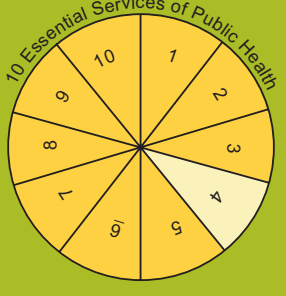
- Create a marketing plan to increase consumer demand for screening that uses evidence-based, culturally appropriate methods to communicate key messages.
- Assure that individuals and network partners know what resources are available to them for screening, diagnosis, and treatment.
- Support network partners to raise awareness with their constituencies.
- Partner with pharmaceutical companies and health plans to sponsor awareness activities about diabetes risk factors and the importance of screening.

Goal: A statewide coalition is supported that includes a broad range of traditional and non-traditional partners to maximize collective resources and to encourage regional and community collaboration for state plan implementation, evaluation, and improvement.

Activities:

- Build statewide and regional coalitions to initiate and coordinate diabetes-related activities, including broad representation from stakeholders.
- Identify resources that will support regional and community coalitions.
- Develop and implement a state coalition communication plan that brings together information about all resources and activities and disseminates new initiatives and data reports of the State Diabetes Network.
- Expand regional and community mobilization for primary prevention of diabetes and diabetes care and education.
- Create a clearinghouse website and e-mail list that can be accessed by all partners, collect ideas and best practices, and create links to state and national resources.
- Evaluate the statewide and regional coalition process itself to determine whether it has made a difference.
- Create an anticipatory planning process with the state Department of Health for new opportunities and emergent problems.

Mobilize partnerships to identify and solve health problems.

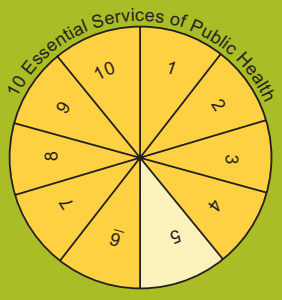


Goal: In recognition of the financial and human impact of diabetes, state, local, tribal, and business entities develop policies and allocate appropriate funding to support diabetes prevention and case management in Washington State.

Activities:

- Quantify return on investment to key stakeholders for diabetes interventions by calculating all pre-diabetes and diabetes costs along with the anticipated impact of appropriate, evidence-based interventions.
- Work with the Washington Health Care Authority, the state's largest purchaser of health coverage, to fund and support diabetes screening, diagnosis, and treatment for covered workers.
- Build return on investment measures into surveillance and program evaluation processes.
- Develop and implement a communication and marketing plan to promote the business case to all identified key stakeholders.
- Provide data and information to the state and other major purchasers to support reimbursement policies in response to demonstrated improvement in outcomes and health indicators.

Develop policies and plans that support individual and statewide health efforts.

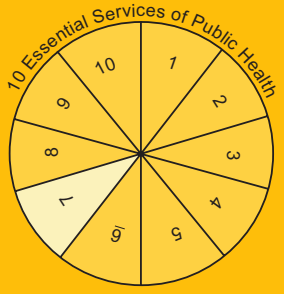


Develop policies and plans that support individual and statewide health efforts.

Goal: The state plan supports evidence-based, culturally and linguistically appropriate, and sustainable strategies that affect social determinants of health and reduce disparities in health outcomes.

Activities:

- Develop and implement innovative, short and long-term primary prevention strategies to reduce health disparities.
- Adapt and spread evidence-based community interventions to create a statewide prevention program for people with diabetes.
- Identify evidence-based approaches and lessons learned, and link them to interventions with current and ongoing research to create innovative approaches.
- Provide information and education to communities—including policy-makers, funding sources, and individuals—about health disparities and social determinants of health, and engage them in implementing the state plan.
- Identify the barriers to quality care for all populations, and educate health care providers and health plans about ways to reduce barriers and provide culturally competent care.
- Develop mechanisms for health promotion that address the social determinants of health and are not solely reliant on the health care delivery system.
- Develop a database to support efforts to address disparities and make this information accessible to regional coalitions and other partners.



Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

Goal: A partnership is maintained between the statewide coalition and other entities that works toward a solution to primary care access, while also using the Institute for Healthcare Improvement (IHI) Collaborative model to improve access in existing clinics through operational improvements.

Activities:

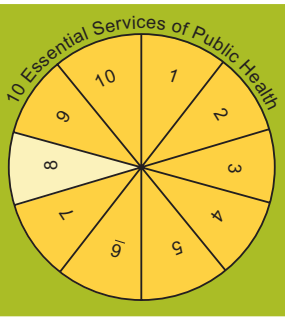
- Look beyond the "medical model" to develop strategies at the regional coalition level to assure access to care for those with low incomes or without health insurance.
- Develop approaches to address barriers to care, especially through communication with racial and ethnic groups, for people who may have access but may not use it.

Goal: An expanded, more knowledgeable health care workforce is supported through a planned, comprehensive, statewide program to increase the skills and knowledge of professional, allied health, volunteer, and lay persons in delivering diabetes-related education, screening, diagnosis, and treatment services.

Activities:

- Engage more of the target workforce in the Chronic Care Model[1] by 2008, especially in rural areas.
- Assure that a range of educational opportunities are available for regular, ongoing training, through such methods as telehealth, continuing medical education, mini-collaboratives for rural practices, and practitioner mentoring processes.
- Make continuing education more available, and require health care professionals, including physicians and pharmacists, to undertake diabetes continuing education on an annual basis.
- Disseminate information regarding diabetes statistics and educational opportunities to motivate individuals in the workforce to seek additional training.
- Expand both the pool and diversity of diabetes educators, using such models as "train-the-trainer."
- Develop a state diabetes delivery system that provides quality care.

Assure a competent public and personal health care workforce.



[1] *Chronic Care Model: This model identifies the essential elements of a healthcare delivery system that encourages high-quality chronic disease and preventive care. It is developed by Improving Chronic Illness Care, a national program supported by the Robert Wood Johnson Foundation with direction and technical assistance provided by Group Health Cooperative's McColl Institute for Healthcare Innovation.*

Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

Goal: A systematic approach to evaluating the State Diabetes Network and the goals and activities of the state plan is conducted and results in performance improvement over time.

Activities:

- Develop an overarching logic model for the State Diabetes Network, establish relevant health indicators and outcomes, and tie the mission and vision to the state plan.
- Develop measurement methods that assure data can be gathered with ease and simplicity, include quality of life measures, and engage partners in understanding the measurement process.
- Assure capacity to monitor the indicators in the business case.
- Assure all initiatives have an appropriate evaluation component.
- Provide technical assistance and toolkits to regional coalitions, communities, and organizations to evaluate their objectives and activities.
- Communicate regarding current initiatives underway and evaluation findings to all state and regional partners, acknowledging successes, providing feedback, and updating with evaluation findings.
- Establish a formal evaluation plan for the state plan with established timelines and accountabilities.
- Apply evaluation results to modify and improve statewide and regional initiatives and to decrease duplication or ineffective programs.

Goal: The State Diabetes Network is knowledgeable of state and federal research projects and results. Research results are used to guide the network's policy and applied to clinical practice through active dissemination of innovative knowledge, methods, and tools to prevent diabetes and to improve the quality of life for people with diabetes.

Activities:

- Develop, implement, and maintain a clearinghouse of diabetes research and results. Partner with other states to influence national groups to maintain a clearinghouse, with appropriate links to national research entities.
- Establish a work group of the state coalition to develop the state's diabetes research agenda and goals for the State Diabetes Network.
- Disseminate all project results through multiple channels to all appropriate partners.
- Create ways to link community programs back to research and ensure that research resources are available to communities.
- Implement projects relevant to the research agenda through partnerships with researchers and funding sources.
- Reflect research results in new, inclusive policies for the State Diabetes Network.

Conduct research for new insights and innovative solutions to health problems.

Appendix

Developing the Plan

The U.S. Centers for Disease Control and Prevention, the federal public health agency that helps support diabetes public health efforts in Washington and all other states and territories in the nation, provides funding for state programs to assess the performance of their diabetes systems and to develop five-year strategic plans. Washington began this process in September 2003, when the state's Diabetes Prevention and Control Program—part of the Department of Health—convened a statewide group of participants involved in designing, monitoring, and delivering diabetes services.

The first step in this process was an assessment of the strengths and weaknesses in Washington's State Diabetes Network. For this analysis, participants used the framework of the 10 Essential Services of Public Health, the critical services that all public health agencies and partners provide to keep communities healthy. The assessment revealed an immediate challenge: defining the components of the state network and their relationship to each other. This was achieved by creating a "map" of the network that identifies organizations that contribute to diabetes prevention and control activities across four sectors:

1. The *public sector*, including state and federal agencies, the Washington Legislature, and schools

2. The *private sector*, including health systems and plans, foundations, professional organizations, and pharmaceutical and supply companies

3. The *community sector*, including state and local community organizations that are governed by community boards such as community health centers, faith-based groups, and non-profit organizations such as the American Diabetes Association

4. The *academic and training sector*, including public and private universities, and nursing and pharmaceutical schools

The sector map helped identify who was in the network; the next step was to align those identified organizations with the 10 Essential Public Health Services. This provided a picture of who was working on what within the network to prevent and control diabetes.

Using findings from the assessment and the mapping work, state planning retreats were held; one each on the east and west side of the Cascades. Participants representing all sectors of the network came together to create 10 goals and about 60 specific activities to close system gaps and otherwise improve diabetes prevention, treatment, and management in Washington State over the next five years. The Washington State Diabetes Network Alignment Wheel on page 15 shows the relationship of the 10 state plan goals, and the agencies and organizations that perform them, to the ESPH. This configuration forms the basic structure of the Washington State Diabetes Plan.

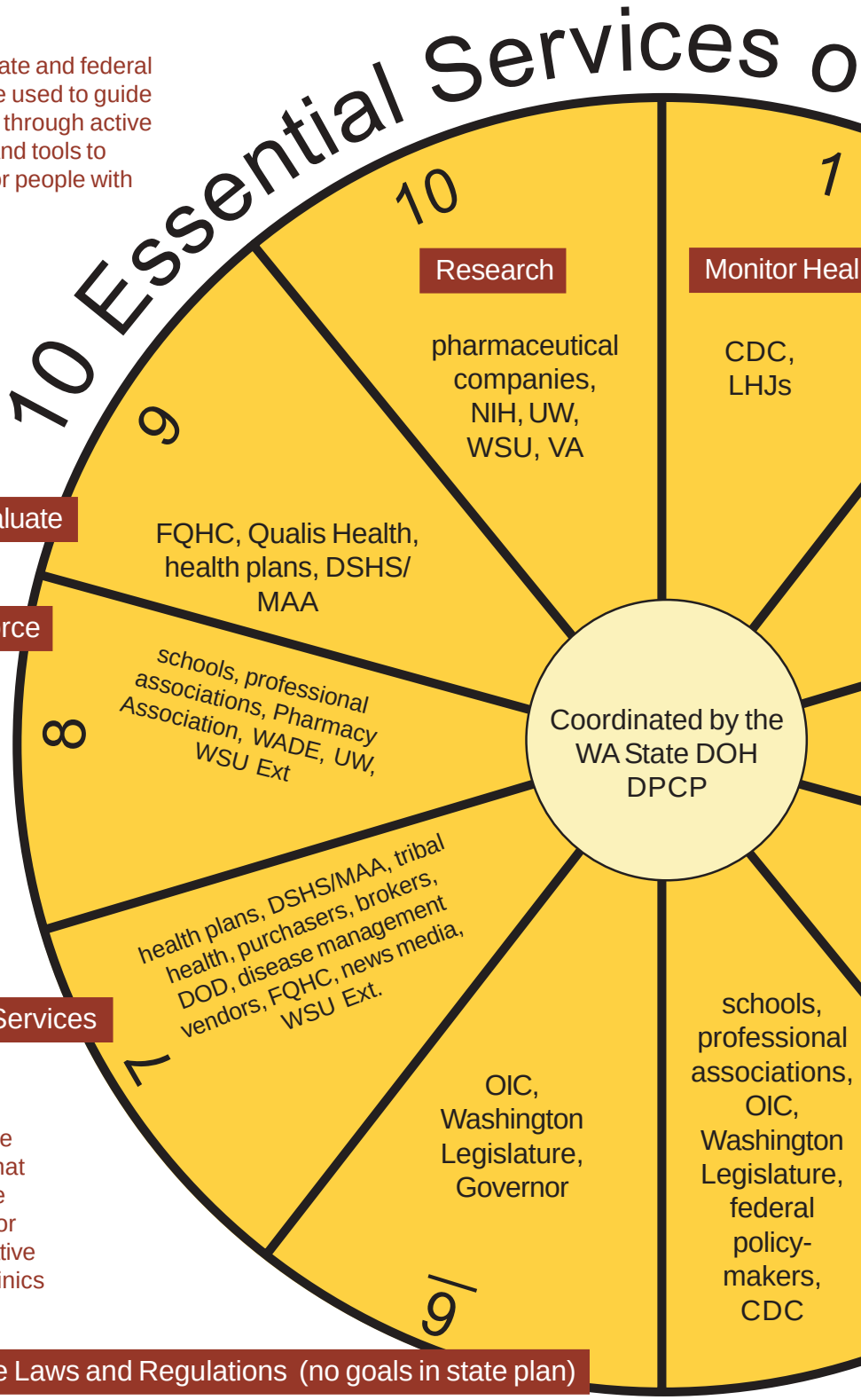
Washington State Diabetes Network Alignment Wheel 2005 - 2010

Goal 10
The State Diabetes Network is knowledgeable of state and federal research projects and results. Research results are used to guide the network's policy and applied to clinical practice through active dissemination of innovative knowledge, methods, and tools to prevent diabetes and to improve the quality of life for people with diabetes.

Goal 9
A systematic approach to evaluating the State Diabetes Network and the goals and activities of the state plan is conducted and results in performance improvement over time.

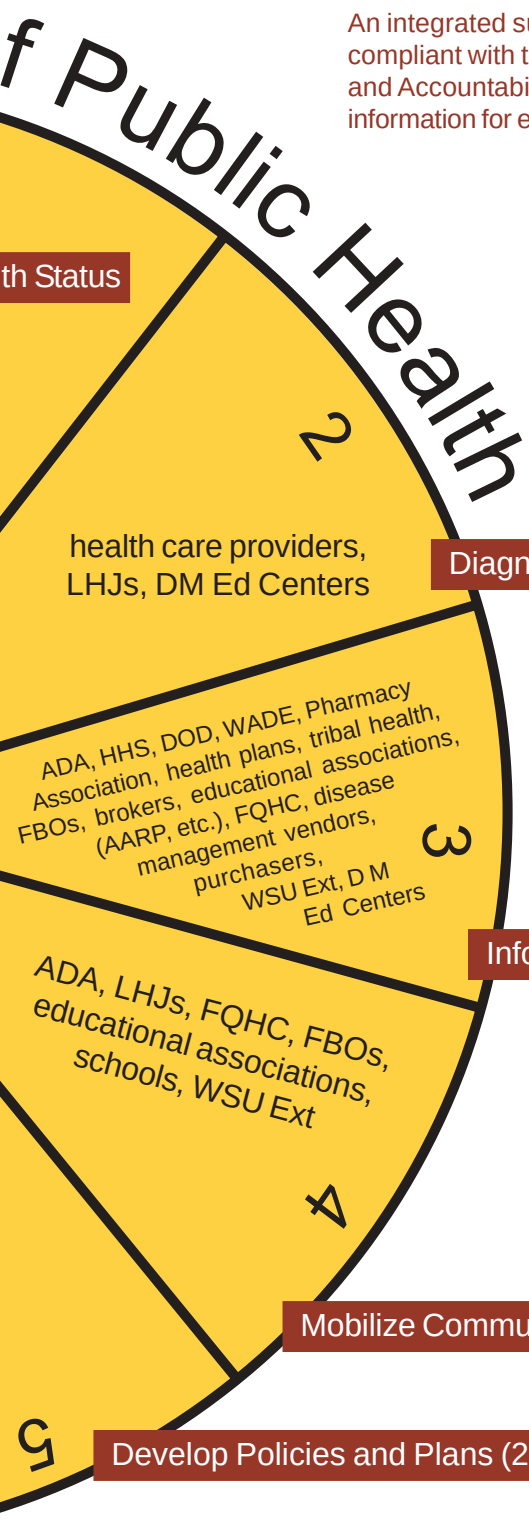
Goal 8
An expanded, more knowledgeable health care workforce is supported through a planned, comprehensive, statewide program to increase the skills and knowledge of professional, allied health, volunteer, and lay persons in delivering diabetes-related education, screening, diagnosis, and treatment services.

Goal 7
A partnership is maintained between the statewide coalition and other entities that works toward a solution to primary care access, while also using the Institute for Healthcare Improvement (IHI) Collaborative model to improve access in existing clinics through operational improvements.



Goal 6
The state plan supports evidence-based, culturally and linguistically appropriate, and sustainable strategies that affect social determinants of health and reduce disparities in health outcomes.

A relationship betweeen the goals, network organizations, and the 10 Essential Public Health Services



Goal 1
An integrated surveillance system is supported that is compliant with the 1996 federal Health Insurance Portability and Accountability Act (HIPAA) and that provides consistent information for everyone.

Goal 2
Comprehensive, evidence-based, and ongoing screening activities are conducted in all high-risk populations, using multiple sites and methods, that identify new cases of pre-diabetes and diabetes for the purpose of diagnosis and intervention.

Goal 3
A comprehensive, coordinated, and measurable strategy is conducted to increase awareness of risk factors for diabetes and to empower individuals to take action to prevent diabetes, get screened, diagnosed, and receive treatment to manage their diabetes.

Goal 4
A statewide coalition is supported that includes a broad range of traditional and non-traditional partners to maximize collective resources and to encourage regional and community collaboration for state plan implementation, evaluation, and improvement.

Goal 5
In recognition of the financial and human impact of diabetes, state, local, tribal, and business entities develop policies and allocate appropriate funding to support diabetes prevention and case management in Washington State.

Acronym Glossary

AARP - American Association of Retired Persons

ADA - American Diabetes Association

CDC - U.S. Centers for Disease Control and Prevention

DOD - U.S. Department of Defense

DOH - Washington State Department of Health

DPCP - Washington State Diabetes Prevention and Control Program

DM Ed Centers - Diabetes Education Centers

DSHS - Washington State Department of Social and Health Services

FBOs - Faith-based organizations

FQHC - Federally Qualified Health Centers

HHS - U.S. Department of Health and Human Services

LHJs - Local public health jurisdictions

MAA - State Medical Assistance Administration

NIH - National Institutes of Health

OIC - Office of the Insurance Commissioner

VA - Department of Veterans Affairs

WSU Ext - Washington State University, Extension

UW - University of Washington

WADE - Washington Association of Diabetes Education

For More Information

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